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ABSTRACT

Designed for parents of adolescents, this handbook provides drug information and suggestions for parental action regarding children's drug use. The first of seven chapters places adolescent drug use in its social context. Chapter 2 describes home prevention strategies. Chapter 3 focuses on the reasons children take drugs. Chapter 4 describes alternatives to drug-taking that parents can offer their children. Chapter 5 describes parental recourse if a child is already taking drugs. Basic information on marijuana, alcohol, heroin, and other drugs is provided in chapter 6. A list of selected readings concludes the handbook. (LP)

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DRUG ABUSE

A Handbook for Parents

by Erica Wittenberg

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INTRODUCTION

If you are reading this handbook, chances are that you're a parent and that you're either curious or concerned about drug use by adolescents—perhaps *your children*. To most parents, the idea that their own children might be using drugs is very frightening. Perhaps the most frightening thought for you is "What kind of *damage* could my children do to themselves?" or even "What kind of damage have they *already* done?" You wonder if the damage could be permanent, and what it would mean for your family. Another frightening thought is how little control you appear to have over what your children are exposed to these days, and what freedom they have to make mistakes. They often seem to be living in a secret society beyond the reach of your advice, your values, or your rules. Information about drugs they are, or may be, using is hard to get and often contradictory. Advice about what you can do varies all the way from "Take a hard stand, and back it up!" to "Relax...and let them experiment. They'll grow out of it. It's just a phase all kids go through!"

You are left wondering how scared or how angry you ought to be, what you can do to inform yourself and your child, and how you can exert some kind of control over the situation. You may also be wondering "*Why* would my child use drugs—where did I go wrong?" In your uncertainty, you may be tempted to blame your child for being bad or weak or crazy. You may be tempted to see your child's drug use as the result of other people's badness or society's craziness, and feel justified, but even more helpless to take postitive action.

The answers aren't simple. They depend on the age of your children, the kinds of drugs they may be using, your values with regard to drugs, and the kind of relationship you have with your kids.

In this handbook, Do It Now offers you some alternatives for action and some basic, unbiased information. We have made every effort to evaluate all current, relevant research on drugs, and to sift out for you what is clearly established fact from what is still controversial, or what is a matter of interpretation.

Unfortunately, this means that what we have to say is often less simple and less direct than the advice given by others.

Some writers believe that there is only one correct way to respond to drug use by young people. Do It Now believes that parents have a number of alternatives available and should carefully consider which might be most effective with their children. We do not question the right of anybody to his or her values and opinions. We do feel that *all family members will benefit from decisions based on all the available facts*—whether they support your original beliefs or not.

In the past, some parents and educators have expressed concern that Do It Now does not often enough condemn the use of drugs. They feel that, by implication, we are condoning drug use. Sometimes we state that a particular piece of research fails to prove that a certain drug is absolutely bad—or that it may not be as dangerous as people have thought it was. Sometimes we state that the information about a particular drug is simply not conclusive at this time. While it's true that we try not to make excessive value judgments on drug use in our publications, that's not because we support the use of drugs. Nor do we discount the importance of having personal beliefs and values about drugs and drug use. We hope that in reading this booklet, you will come to your own conclusions and make your own judgments. Those conclusions and judgments are valid for *you* because *you have the right to make them*, not because we, or anyone else, said they were correct.

In the next chapter, we'll try to show you that the use of drugs by young people is not an isolated problem. It has roots in many of the social and economic changes going on in our world today. That fact suggests some of the things you can do to make drugs less tempting to your kids—and less important in their lives.

In other chapters of this book, we'll talk about the reasons kids do drugs. We'll describe a prevention program you can use at home—starting when your kids are toddlers. We'll talk about what you can do if your kids are already using drugs. We'll give you some basic information about common drugs. And we'll suggest some books and resources in which you can get additional information. The rest is up to you.

CHAPTER 1

PUTTING ADOLESCENT DRUG USE IN A SOCIAL CONTEXT

To start with, let's look at the society you and your children live in. It has undergone some fairly extreme changes during your lifetime.

During the period of relative affluence since the end of World War II, adolescence has become longer—there is less need for young people to become financially responsible for themselves or their families at an early age. The rapid growth of technology has created a demand for highly trained workers, which tends to increase the average young person's period of education. These changes have contributed to a gradual lengthening of the period we recognize as "childhood." There is a longer time during which we see young people as still needing support and guidance from their parents.

At the same time, this country has experienced a period of intense questioning of old values and authorities—and not only on the part of the young. Families have become more mobile. Young people grow up away from extended families and small neighborhoods where values were largely shared and reinforced by the whole adult community. In recent years, economic and social changes have promoted the growth of one-parent families and families in which both parents work outside the home. Young people are used to hearing rules and customs questioned, to seeing people experiment with new ways of behaving. They don't live under the watchful eyes of adults who know them as they once did, either at home or out in the community.

So young people are being seen by society as the responsibility of adults for longer periods of time, while it becomes more and more difficult for the adult community to carry out that responsibility. Young people live for five to 10 years in a "never, never land" in which they are neither children nor adults, in which they develop a culture which is largely separate from that of the adults and which absorbs new members at increasingly younger ages.

It might be helpful, at this point, to remember that these things would be true even if the use of drugs had not reached epidemic proportions. *Drugs did not create this situation.* But the increasing

isolation of the adolescent subculture from the rest of the community raises more frightening questions for parents when drug use is considered.

The answers have much to do with bringing back the lives of young people into the life of the whole human family, in a way that doesn't isolate them nor treat them as babies. The direct control of drug use is only incidental to that process.

CHAPTER 2

FACTS AND VALUES BOTH COUNT— THE FAMILY CONTEXT

Making decisions about behavior that *feel right* to us is often a difficult task—at any age. One of the things that makes this task difficult today is the variety of values that exists with regard to many issues—including the use of drugs. This is not necessarily a "bad" situation, nor did it occur without the participation of adults. It gives all of us an opportunity to *choose* the values by which we live—and to question and modify those values as we test them against our life experience. *People of good will and intelligence have always differed in their beliefs.* This is perhaps the first time in history that a society has permitted those differences to be expressed as freely through people's chosen lifestyles as we do today.

So our children question our values, as children have always done—and they will be able to see around them examples of people shaping their lives in many different ways, and apparently surviving! Parents may well despair of being able to ensure that their children learn and live by the same values that they cherish and rely on. That despair is realistic.

It is impossible to "win" a contest of values by convincing someone else of your "rightness." Usually, each of the combatants become convinced that the other is foolish, untrustworthy, and possibly a danger to himself/herself and others! Adults may be able to "agree to disagree" and continue to respect each other. It is often terribly hard for parents and children to give each other the same kind of respect.

"Well, of course," you may say, "I have a responsibility to teach *my children* how to live that I don't have for other adults. . .and besides, the fact that I'm older means I know more about the world and its dangers. I only want my children to be safe, and to have the respect of others for the way they live. . . .My values have worked for me, I want my children to respect them. And I want my child to respect ME."

We agree absolutely that you have a right to uphold your own values, and to have them respected by others. As a parent, you also

have the right to decide what is acceptable behavior in your home—not because everyone in the family agrees about what is right. Your preference is your privilege.

You are the head, or co-head, of your household. We think it is important for you to let your children know very clearly what your values are and what the rules are for living in your home. But we think it is probably futile and even destructive for you to insist that your children share your values or agree that your rules are the "right" ones. Your insistence only increases their need to argue back. *Your arguing with them suggests that if they only come up with powerful enough arguments, their values will prevail.* Then they can decide what the rules will be. That's unrealistic, of course.

You can stay in charge, and both you and your kids can all retain some dignity if neither side is considered to be "on trial." By all means, state your position in a friendly way. You can afford to when you don't need their agreement. You can listen respectfully to their ideas, and let them know that the final decisions are still yours.

Because children, as well as their parents, want to believe that their point of view is the "right" one, the family may also be tempted to get into a "fact" war. Each side tries to present the facts which support their beliefs. The whole area of drug abuse is a tricky one in this respect. Much of the older research has been performed by people who had an "axe to grind." Some of it was poorly designed and often could not be reproduced, but it was still "scientific research," and, therefore, likely to be quoted by whichever side it favored—and often quoted incorrectly. In recent years, the quality of research into drug use and effects has improved considerably. In some cases, however, it only shows that there are still questions we cannot answer with certainty.

We urge you, as a parent, not to attempt to "win" a war of values or facts with your children over drugs and drug use. Rather, we encourage you to state your values and make household rules consistent with them, without necessarily demanding or expecting agreement.

We, on our side, will heed our own advice. We will not demand that our readers come to any particular conclusion as a result of reading this handbook; we only hope that it will be helpful to you as a basis for coming to your own conclusions and making your own judgments.

In the next chapter, we'll take a look at the many reasons *why* young people use drugs. We'll also look at *how* they use them, and supply some useful definitions.

CHAPTER 3

WHY KIDS TAKE DRUGS—HOW KIDS TAKE DRUGS

If your children, or their friends, are using drugs, they may be doing it for any number of reasons. Although you may feel that *any* kind or amount of drug use is unacceptable, some reasons signal trouble more clearly than others. In deciding how to deal with your child's drug use, it may be helpful to consider how that usage started, and what's keeping it going.

Let's begin by saying that people of all ages use drugs for the same reasons anybody does anything. They are trying to meet a variety of *universal human* and *legitimate* needs. We all choose the means most available, effective, and acceptable to us at the time to accomplish our goals. Using drugs is the way some young people choose to:

- satisfy their curiosity
- feel included in their social group
- feel more at ease in social or work situations
- deal with strong feelings of anger, loneliness, fear, or sexuality
- establish an identity separate from that of their parents
- fill time (kill time?)
- have unusual and pleasant experiences just for fun
- have adventures

The need to do any of these things is not usually, *of itself*, an indication that a person has some serious problem—whatever we may think of the means he or she uses to accomplish it. These are needs that normal adults as well as normal adolescents experience from time to time. The major difference is that young people may feel these needs more urgently, and have fewer resources to deal with them.

The almost universal availability of drugs on or near the school campus, playground, or arcade makes it highly probable that your children will at least consider using drugs at some time for one or more of the above reasons. It's also probable they'll have acceptance among many of their peers for doing so.

Even if the first experience is a bad one, encouragement to continue may be strong. Very possibly, the experimenter will discover that the short-run effects are highly satisfactory and easy to obtain.

If your children are using drugs for any of these reasons, you won't help yourself or them by insisting they have a serious psychological problem that must be unearthed and treated. Chances are, your children will be convinced that you see them as freaks and that your judgment is not to be trusted. If your goal is to help your children meet these normal needs in ways that are more acceptable to you, then that's the most logical place to start. We'll say more about how you can do this in the next chapter, when we talk about "drug-proofing."

There are indeed reasons for drug use that should be read as danger signals. And they are as applicable to adults as they are to kids.

Some people take drugs as a way of "medicating" themselves. They may be suffering from chronic pain or chronic severe stress. They may be having thoughts or feelings that make them afraid they are going crazy (or have already *gone* crazy). They may feel they're expected to live up to standards, set by others, that they are unable or unwilling to meet. They may feel locked into a living situation which is intolerable to them and yet is seemingly inescapable. And they may not feel able to solve these problems by direct means which would require "public" declaration of the problem. Perhaps they believe that the problem is actually insolvable—or that the price of solving it directly would be unacceptable.

Even very unhappy children are often unwilling to violate family rules about confronting others, about appearing sick or weak or selfish, or about being responsible. Kids who are very angry or scared will still loyally protect family solidarity by keeping family secrets. Sometimes a symptom such as drug use is really a "cry for help"—not only for the drug user, but for the whole family.

In other cases, children are "taught" by their families (often quite unintentionally) that they are not really expected to be responsible for themselves, that they're not capable of doing so, or that, in fact, no one is, or can be. This is a seriously mistaken and potentially crippling view of life—whether or not drugs are used to maintain it.

And of course, some adolescents, like some adults, are addicted to the drugs they are using. This means that getting and using drugs has become an end in itself, and often a costly and time-consuming one. The word "addicted" has many different meanings for different people. It is worth taking some time to examine what they may be, and to establish how we'll use the word in this handbook.

1. Certain drugs, such as opium derivatives, barbiturates, and alcohol create "PHYSICAL DEPENDENCE." That is, *after being exposed to these substances for a certain length of time, the body can no longer function normally without them.* Cutting off the drug will bring on physical symptoms (sometimes called a "WITHDRAWAL SYNDROME") that are directly linked to the absence of this chemical in the body. Withdrawal symptoms may or may not be dangerous in themselves, depending on the type of drug involved. We'll touch on this again in Chapter 6, when we discuss "Basic Drug Information."

2. Certain drugs cause "TOLERANCE." After taking the drug for a while, the user must take *a larger amount to get the same effect* he previously got with a small amount. Most drugs that cause physical dependence also cause tolerance, but the reverse is not necessarily true.

3. Some drugs have a strong potential to create "PSYCHOLOGICAL DEPENDENCE." The user finds the effects of the drug so pleasant and effective that he or she is not willing to give it up. Attempts to do without the drug may be accompanied by extreme anxiety or depression. Physical symptoms associated with psychological dependence can include insomnia, restlessness, appetite loss or increase, upset stomach, headaches, irritability, etc. Although physical in nature, these symptoms are due to the psychological stress of doing without the drug (and perhaps due to a stress the drug was taken to avoid in the first place), rather than the body's need for the chemical involved.

Because the terms we have used above (the ones in capital letters) seem more precise to us, we won't use the word "addiction" at all. Instead, we'll specify whether we are referring to PHYSICAL DEPENDENCE, PSYCHOLOGICAL DEPENDENCE, or TOLERANCE. One more comment: Because the idea of physical dependence has many frightening associations for the average person, you may tend to assume that it is a good indicator of how "dangerous" a particular drug is. This is not necessarily the case. In the part of this booklet where we discuss individual drugs, we'll try to give you a clearer idea of what makes a particular drug any more or less dangerous than other drugs.

HOW DOES MY CHILD USE DRUGS?

You may feel that any use of any drug by anybody is dangerous or unacceptable behavior. However, you may find it useful, in understanding what your children are doing and in discussing it with them, to think in terms of different *levels* of drug usage. It may help you and your children to get some perspective on their drug

use that fits the real situation, and avoid damaging your credibility with each other. You can see that each of the stages described below might call for a different response on your part.

Contact Stage/Experimental Use—In this stage a person expresses curiosity about a drug or drugs. He or she may seek out an opportunity to experiment, or may simply take advantage of an opportunity that presents itself. Satisfying this curiosity may lead to no further use, or to spontaneous, unplanned use when the drug is easily available. For many people, drug use stops or remains at this level. *It is not inevitable that use will continue or increase.* To a great extent, that depends on your child's reasons for experimenting, on the satisfactions and strengths in his or her life, and on how you deal with this initial situation.

Try to express your feelings and thoughts without making your children feel like hiding from you. You are more likely to be trusted in the future with information about their activities.

Integrated Use—In this stage the individual may plan ahead to obtain and use the drug, involving more time, thought, and money than in the previous stage. However, usage tends to be casual, mainly in social situations, and the user's ability to function in his or her daily life is not impaired. These first two levels are comparable to the alcohol consumption of the stable "social drinker." *About 90 percent of the drug-using population falls into these first two categories—experimental or integrated use.*

Excessive Use—In this stage the user devotes a substantial amount of time, energy, and money to obtaining and using one or more drugs. Drug use may be solitary, or may take place in social situations where drug use itself is the central activity and the primary reason for the get-together. Preoccupation with the quality and effects of drugs becomes noticeable. Psychological and physical impairment becomes apparent. Daily functioning is noticeably affected. Responsibilities are neglected. Relationships with others become strained and may go downhill rapidly. Family members may find themselves making excuses for the drug user, or taking over tasks that are really his or hers. Many heavy drinkers who would not consider themselves alcoholics are actually in this stage.

Psychological/Physical Dependence—Damage is clearly present, and use of the drug has become an end in itself. Obtaining and using the drug takes priority over many normal and necessary daily activities. Ability to function physically, psychologically, and socially is clearly impaired.

Ability to stay in school or hold a job is shaky, at best. Few if any friends remain who are not heavy users themselves. Involvement with the police and court system becomes likely—*if* it hasn't already happened.

You can see that answering the question: "Why does my child use drugs?" may require some candid examination of your child's family and social environment. In some cases, answering the question "why?" may be impossible or not particularly useful. In other cases, it may be very important. "How?" is also an important question, and one that's often much easier to answer. In most cases, you are probably in the best position to make this distinction yourself. Still, you may want professional consultation from a substance abuse program, family counselor, or youth services agency to decide exactly what problem or problems you and your child are encountering and how best to go about resolving them. A good place to start might be your family physician or clergyman. Usually, he or she is already familiar with your family relationships, and any other problems that may have a bearing on this one.

CHAPTER 4

"DRUG-PROOFING"—GIVING YOUR CHILD ALTERNATIVES

Once you accept the idea that kids use drugs for understandable reasons, you have taken several steps in the direction of helping your children find acceptable and effective alternatives to drug use. Let's look again at the simplest and most common reasons kids use drugs, and see what they suggest.

CURIOSITY—Certainly this is not a quality you would want to discourage in your child. However, there are many ways in which we satisfy our curiosity about the world which don't call for putting ourselves in potentially dangerous situations. We suggest that the family make a habit of procuring and discussing information on a variety of topics—including drugs and drug use. Some parents are very reluctant to talk freely with their children about certain topics—such as sexuality, drugs, or "different" religious or political ideas—because they are afraid to "give the kids ideas" or encourage them to indulge in behavior that is contrary to the parents' values. Although these fears are understandable, they are rarely justified. People are far more likely to experiment with behavior that has the lure of "the unmentionable." They are far more vulnerable if they are ill-informed, or if they are prevented by the need for secrecy from getting the information that might help keep them safe.

Frequently, parents simply wish to avoid discussions that arouse their own fear, anger, or embarrassment, or expose their own ignorance. It seems easy to rationalize our avoidance of these difficult feelings by giving our kids the message "We don't need to discuss these things in our family" or "You're too young to be asking such questions!" A family in which gathering and discussing information freely is a shared and valued activity allows your children to satisfy some of their curiosity without actually experimenting. It gives them access to *you*, and to potentially life-saving information.

FEELING INCLUDED SOCIALLY—This is a very strong need for many of us. You probably wouldn't want your child not to care at all what others think of him or her. In fact, you've probably urged your kids to consider the opinions of other people on many occasions. That's a big part of how we learn what's acceptable

behavior in our families or our communities. It's natural for children to care what *their* friends think of them, too. For all of us, it's important to have a sense of social balance. We need to give attention to doing what is appropriate or expected in social situations. Often that means doing what everyone else is doing.

At the same time, we need to be able to use independent judgment. We need to be free to behave differently from others if that is in our own best interests. It may be difficult for you to allow your children to exercise their judgment in this way at home, or to support them in doing so elsewhere—at school, church,etc. But if they don't have your support in differing from you, or from other adults, on some occasions, how are they ever going to be able to be different from their peers? Obviously, there will be times when you have to insist on certain behavior just because it is "expected" or "what everyone does" in a given situation.

Practice encouraging your children to be aware of their own preferences and best interests—and to act on them whenever there is no compelling reason to do otherwise. You won't like all of their choices. The point is to teach them (and yourself) that friends *can* like and do different things and retain respect and liking for each other.

There is another way in which you can help your child feel at ease socially, without drugs. That is by modeling social ease yourself. Include your children in the family's social life as much as possible, in a natural, unforced way. Help them to feel at ease and welcome, *and* to have the expectation that they are likable and acceptable in other people's eyes without having to "perform" in some way or to conform beyond what is truly necessary. Talk with them in a non-lecturing way about the "how to" and the "why to" of handling various social and work/school-related situations. Knowing what is accepted behavior can give your children social confidence. Feeling that their self-worth depends on conformity or performance destroys that confidence. It tends to make them feel that they need all the extra "help" they can get to socialize.

DEALING WITH STRONG FEELINGS—Adolescence is typically a time when all of a person's feelings are extremely powerful and seem to be constantly shifting. It's not unusual for teenagers to feel out of control, embarrassed, or tortured by their feelings. As if that weren't enough to deal with, they must respond to the peer group's admonition to "be cool," and their parents' expectations of adult self-control.

How can you help? You can start by teaching your children that NO feelings are bad in and of themselves—that what is important is how we express our feelings and what we DO about them. There are no rules for what we "should" or "shouldn't" feel in a given situation. *We feel whatever it is we feel.* Families and close friends are most

supportive and helpful when they can listen to each other's expressions of feeling without criticism, without having to blame them on something or someone else. We do kids a disservice when we try to take their feelings away from them under the guise of "trying to make them feel better." *Feeling better is the business of the person having the feelings.*

We all need to know that strong or unpleasant feelings won't kill us. They are part of being human. We can learn to accept them in ourselves *and* in each other. We need to learn that it is our *behavior* that counts. We can accept our own and each other's feelings without having to accept hurtful behavior that is dictated by them. Accept your child's anger, envy, fear, dependence, independence, sexual feelings, and curiosity as natural. You will be in a much better position to help him or her accept those feelings, too. You will also be in a better position to guide his or her behavior without damage to the child's self-esteem or to family relationships.

ESTABLISHING A SEPARATE IDENTITY—The major developmental task of the teenage years is to develop a sense of being a separate and complete person. That is, someone who can support himself or herself emotionally, intellectually, and economically, without reliance on parents.

This is likely to be a difficult time for both parents and teenagers. Both have mixed feelings about the coming independence and departure of the young person from the family circle, or at least from the parents' household. Frequently, angry and rebellious behavior marks the teenager's struggle to feel and act independently without having to give up family support that is still needed and wanted. Drugs can become a welcome ally in this struggle. Using them can be both an act of independence from parents and of solidarity with peers. If the young person is feeling overwhelmed by the real or imagined demands of adult life for which he or she must prepare, drugs can ease those feelings.

You can help in several ways to make drug use a less attractive means to independence. One way is by giving growing children plenty of occasions in which to exercise their independence. Parents sometimes retain control in areas of a child's life where it may no longer be appropriate. This may be because they wish to save their child the pain of making mistakes. They may exaggerate the seriousness of the consequences if a mistake is made. They have difficulty in accepting the "differentness" of their children's preferences and values (even on relatively trivial issues). Perhaps they simply feel anxiety in relinquishing any control at all. As your children approach their teenage years, consider whether it is now time to give *them* the responsibility for choosing their clothes, choosing their friends, getting their school work done, cleaning their rooms, spending their allowances, getting along with other

family members and friends, etc. When you make a rule, or even a comment, that limits a child's area of independence, make sure that it is really a necessary and useful one.

You can help your child understand that increased independence means increased responsibility. Try not to shield your children from the natural consequences of their choices. Try to help them find solutions to any problems they've created without telling them what to do or saying "I told you so!" Admit, in a non-judgmental way, that they have a responsibility to change or resolve the problem situation, and that you expect them to do it. Help clarify alternatives and consequences. If you are willing to help in some specific way, say so, but don't take away from your children the freedom to accept or reject that help. This strengthens their ability to trust themselves in using their independence wisely. It strengthens their resolve to keep learning about life, through their mistakes if necessary, instead of being overwhelmed by a sense of helplessness or failure.

And of course, you can help by *modeling* for your children the attitudes and behaviors you'd like them to adopt: independent thought and action; cheerful acceptance of responsibility for your own life choices and their consequences; resourceful, confident persistence in the face of difficulties; refusal to waste energy on self-reproach that is not directed at changing the situation,etc.

FILLING TIME, HAVING PLEASANT EXPERIENCES, HAVING ADVENTURES—Sometimes it's hard for adults to take these needs seriously. Our time may be too full, and not with pleasures. Our struggles to survive may have dulled our appetites for adventure. It can be particularly difficult for single parents to respond to these needs in themselves and their children. But being "high"—that feeling of excitement and pleasure in just being alive in the present moment—is a normal state for human beings. It is how we "recreate" ourselves. People get to the state of being high through many different routes: sports, playing the stock market, dancing, music, star-gazing, making love, talking, celebrating together, being alone in the mountains or desert or ocean, participating in religious ceremonies, etc. Anything that takes us beyond our normal limits of feeling or doing, or anything that tests us or brings us into greater harmony with the world or each other has the potential to make us "high."

Drugs are a very seductive "high" because they require no effort on our part beyond obtaining and taking them. Their effects are usually predictable and reliable, and more intense than the effects a depressed or anxious or overly dependent person can hope to achieve on his own.

You can help by supporting your children in choosing and following through on activities that give them good feelings about

themselves and about being alive. You can help this process along by *valuing* "high" feelings that come from personal effort and increased awareness. You can initiate family activities and activities with other families that give children a chance to share high feelings and experiences with parents and brothers and sisters, as well as friends. You can help by avoiding turning your own or your children's leisure time activities into duties, and by stressing that it is worth striving to find occasions for joy even in necessary work, or in troubled times.

Last, but very far from least, give some thought to what you are modeling for your children in the area of drug use. Do you smoke upwards of a pack of cigarettes a day? Do you talk about the rough day you've had, then reach for a highball or a beer? Do you drink till you're drunk? Do you expect your family to see you as someone who "needs" tranquilizers or sedatives to meet the normal strains and stresses of life? Do you treat intoxication of any kind as a joke, or as an acceptable excuse for inappropriate behavior? Do you refuse your responsibility to eat and sleep according to your body's real needs—and then rely on excess coffee or sweets to get you through the day? If you do any of these things on a regular basis, you are giving your children a message that substance abuse is okay with you. The only question that remains for them is to decide which substance *they* will abuse.

We are not suggesting that the only way to have drug-free children is for you to give up all use of alcohol, cigarettes, coffee, or properly prescribed medications. We are strongly encouraging you to be careful in *how* you use or talk about these things. Modeling responsible use means that you use such substances in moderation. It means that you use them for pleasure, not out of an imagined *need*. It means that you use medications only as prescribed and only for their intended purpose. It means that use is *always* seen as a matter of choice, not compulsion. It might mean learning, and teaching your children, how to reduce the tensions of the day without chemicals, how to live a lifestyle planned for health maintenance.

What we've been talking about, when we talk about "drug-proofing," really amounts to a whole philosophy of life. We'd like to see all children raised this way, starting as toddlers. Like any philosophy, the earlier a person is exposed to it, the more profound its effect is likely to be. If your children are already teenagers, and are already using drugs extensively, making the kinds of changes we've suggested may still be very helpful. Certainly we hope you will make the effort to try them out. However, it *will* take some time for your kids to believe that you really *do* mean to make changes, and to trust that you will stick with them and to respond positively to them.

With older teenagers, it's possible that the positive effects of any changes you make will not show up until after they have left home.

You may need to settle for paving the way to a more constructive relationship with them in the future. You may need to concentrate right now on limiting the ability of their drug use to cause further inconvenience or harm to themselves, to you, or to other family members. If you have any reason to suspect that a child is encountering some of the more serious difficulties we referred to earlier, you would do well to consider professional counseling that involves the *whole family* in understanding and working on the problems.

If your children are still young, or are not using drugs extensively, we think that attention to the ideas we have outlined will help to make such use less likely. We believe you can use these ideas to help them grow into resourceful, independent, playful people with genuine liking and respect for their parents and their friends—*and* a sense of responsibility for producing their own good feelings.

CHAPTER 5

WHAT YOU CAN DO IF YOUR CHILD IS USING DRUGS—YOU HAVE ALTERNATIVES

Suppose you have reason to believe, or know, that a child of yours is already using drugs. What can you do? What should you do first?

Probably your first task will be to deal with your own feelings, whatever they are—denial, shock, anger, fear, shame, guilt, the need to fix blame, etc. These feelings are quite understandable, but they will not help you in responding effectively to your child's drug use. Talk the situation over with your spouse, and with trusted friends. It's important that you understand that you're not alone, and that this isn't an indication that you're a bad parent—or that you have a bad child.

It's very important that *both* parents agree on an appraisal of the situation that *both* can live with. They may privately differ in their feelings and opinions about the child's behavior and how they should respond to it. However, no effective action can be taken if the two parents are at odds with each other and are using the situation to carry on that conflict. They are likely to sabotage each other's efforts in subtle or direct ways. They are likely to give the children very confusing messages as to how their parents feel about drug use, whose responsibility it is supposed to be, and what is expected. *Sometimes, in the grip of a distressing crisis, it is hard for partners to be cooperative and to resist blaming each other.* If this is the case with your family, it is a definite indication that *family counseling might be helpful.* The counselor has no vested interest in assigning blame or "rightness," or in taking sides. The counselor's main purpose is helping the family discover what keeps it from functioning cooperatively and from finding healthy alternatives.

Once you have dealt with your initial reaction and worked out a mutually supportive approach with your partner (or any other adults who have responsibility for your children), the next step is to gather information. What drug(s) is your child using? How much? How often? Who else is involved? What else has changed in your child's behavior or functioning? Be specific. Some of this information may

come from your own observations. Some may come from your child or from the other kids in the family. Some may come from the school nurse, or from counselors, teachers, etc. This information will help you assess the level of your child's drug use.

At this point, you need to remember that you have a number of alternatives. You can do nothing and hope for the best. You can confront your child with your awareness of his or her drug use and see where you want to go from there, exploring the situation with the child as you gather information. You can let your child know how you feel and what the rules are. Those rules can allow for anything from no drug use whatever to some conditions under which it is acceptable. You can set up consequences for breaking the rules. You can treat the situation as a problem that involves your family alone, or you can seek to involve the families of your children's friends.

If some or all of your children's friends have been experimenting with drugs, it's likely that some of their parents will feel uncomfortable and become defensive in openly discussing the situation. However, these parents can use the support of other adults in resolving their feelings, working out what actions they will take, and jointly implementing those decisions. The kids will benefit from being part of a community where adults feel a shared responsibility for their welfare, and where expectations and rules are clear. They will benefit from being members of a community that includes them with other children and adults for play and for useful chores. Even if the rules vary from one household to another, it helps if each parent can say clearly "This is what is expected in *this* house." Each parent shows respect for himself/herself, and also for the household that has different rules or values. The "content" of a specific household's rules is not nearly as important as the fact that rules exist *and* that they are understood by the whole family. It is vital that rules be impartially and consistently enforced. It is very helpful if the adults in the family respect the mutual needs of neighborhood families to "parent" their own and each other's children.

It may not be possible to establish a parent group in which every family in your children's social sphere is willing to take part. Some parents will not want to acknowledge that a problem exists—or that it could affect *them*. Some parents will choose household rules that are so much more lenient—or restrictive—than most that cooperation may seem very difficult. Some parents have personal difficulties that prevent them from being clear, firm, consistent, or cooperative.

Some parents, particularly single parents, may simply have enormous *practical* problems in providing effective supervision or adult companionship to their children. It is worth making continued efforts to include everyone in any way that you can. Listen to their

ideas, share the group's information, wisdom, and support with them, and try to find ways to work around the differences that may exist.

If you would like an opportunity to attend a meeting of a parent's support group, or to get help in starting one, you might see if there is a chapter of an organization call "Toughlove" in your community. Contact local substance abuse agencies, school counselors, or youth organizations, or write to the organization listed in the "Selected Readings" section of this booklet for further information.

It's important that children know that adults are aware of the use of drugs in their group, that the adults are concerned about drug use, and that they have a working agreement to enforce mutually accepted rules. The point is not to make the kids feel policed or threatened, but to provide a community of families with mutual concern for their well-being.

GRADE SCHOOL

In many communities these days, drugs make their first appearance in elementary school. Kindergarten is none too soon to begin talking actively with your children about illegal drugs. We would hope you'd already started talking with them about smoking, alcohol, and medications—sharing factual information and letting them know your feelings.

Friendly but consistent supervision is important. Now that your children are going to school, they may be playing with a different group than in their pre-school days. This is a good time to get to know the parents of *all* your children's friends. You may want to establish a support system for the supervision of the kids after school. You might make an effort to establish some common rules about mealtimes, curfews, homework, *and* drug and alcohol use. Share the work of transporting children to various activities, plan occasional informal social events together if some families aren't part of your usual social group.

Find out what your child's school offers in the way of drug abuse information and prevention. Find out who is responsible for these activities. It may be a school counselor, the nurse, the security personnel, a teacher, or someone on the administrative level. Find out what kind of training this person has, and how information is given to students and parents. If no such activities exist, you may want to meet with the PTA or the school principal to see if they can be started. You may want to volunteer time to help set them up. Be prepared to hear "We don't have those problems here" or "These kids are too young to talk about drugs" or even "The other parents wouldn't like it." Don't believe those statements—keep working on it!

It is unlikely, though not impossible, that your grade school child has gone beyond *experimenting* with drugs. While the discovery of any amount of drug use deserves your prompt concern and attention, we caution you against reacting with rage or panic. Little more than a child's natural curiosity or naiveté may be at fault. *It will not help to make your child afraid or unwilling to discuss his or her behavior with you.*

Let your child know in a friendly way that you consider drug use a serious matter, and that you need to know more about what he or she has taken. *Make room for your child to tell you this*, and also the circumstances under which it happened. Remember that your child may be frightened—of your disapproval or of what the drug might have already done to him or her. Give careful thought before you decide that punishment is the answer. It may be more appropriate to be serious and reassuring—and to state clearly that the drug use must not continue.

You may wish to contact the parents of any other children who are involved. Let your child know you are doing this, not as a threat, but because other parents share your concern.

JUNIOR HIGH SCHOOL

If your children are somewhat older—say junior high school age—when you discover that they have been using drugs, you may have some different issues to consider than with younger children. Older children are more mobile—they and their parents may expect them to need less supervision, and to range further from home in their after-school activities. To the extent that they can handle more responsibility, it is appropriate for them to have more freedom. You can expect, therefore, a more difficult time getting cooperation and consensus from other parents, as well as more resistance from the kids. At this age, there is a greater possibility that your child's drug use will have progressed beyond the experimental stage to a more consistent pattern of use. A greater variety of substances may be involved, including alcohol. In addition, many youngsters at this age are beginning to want much more privacy for thoughts and conversations than formerly, to expect less intrusion from the adults in the family, and to find it more irksome and embarrassing.

Quite aside from any specific fears they may have about a child's behavior, many parents react to this change in their child by feeling rejected or out of control, and by becoming even more insistent. If control is not exercised tactfully at this stage, you risk increasing the child's secretiveness and resistance at exactly the point where mutual respect and communication are most crucial.

The trick is to AVOID TAKING YOUR CHILDREN'S BEHAVIOR PERSONALLY! Does that sound like a strange thing to say about your own kids? The fact is that they're likely, at this age, to be critical

of you resentful of control, manipulative, and tempermental—in short, hard to live with! Try to remember that they are not really doing anything *to* you. They are simply responding, in the best way they can, to the physical, emotional, and social changes they are experiencing, changes that insistently urge them toward adulthood. They are simply doing what they are meant to do at this age.

And what are you, as a parent, meant to do? Your job is clearly not over yet. Your kids still need your support, guidance, and discipline. Now more than ever, you need to be able to provide these things with firmness, clarity, good humor, and a touch of impersonality. If you feel rejected, attacked,or out of control, try to see that as *your* problem, not your child's. You don't have to like or even accept their behavior toward you, but *your* feelings are *your* responsibility.

This is a time to begin looking to the end of your career as a parent. Do you need to develop sources of activity, achievement, companionship, or self-esteem separate from your kids? Do you need to do some repair work on your marital relationship? On your social life? We're not suggesting that you start ignoring your kids at this crucial time in their lives, but that your own good feelings need to be independent of their struggles to grow up.

HIGH SCHOOL

Most of what we've said about junior high school age children can be said again, and doubled, for high-schoolers. Older teenagers are increasingly mobile, and increasingly immersed in their own peer society. They may stay out of the house a great deal, for reasons both legitimate and otherwise. When they are home, they may spend much time hidden in their rooms, insulated from the family by closed doors and loud music. Their interaction with the rest of the family may appear grudging and superficial. It's hard for parents not to wonder what they're up to—and hard, sometimes, not to assume the worst.

The fact is, your ability at this point to impact positively on your adolescent children's lives depends to a large extent on the reservoir of mutual good will, respect, and trust you've stored up earlier. If they are to learn to function as independent, competent adults, then they have to begin to live more independently of you. There is much about their lives that you will know for sure only if they re willing to tell you. Trying to establish whether you are being told the truth can be futile, and create further conflict. You may have to accept the fact that you will not always know where, or how, or with whom, they spend their free time.

It is still important that you be clear and firm about your own values, preferences, and rules. That is simple self-respect. But you may not be in any position to extend your rules very far beyond the

confines of your home. You may not have the information or the physical control to see to it that your rules are followed or enforced. What *can* you do? That depends a good bit on your individual family situation. Here are some suggestions:

Avoid getting into a power struggle with your child over whether or not he or she is using drugs. Concentrate on those *behaviors* that you feel are important to you and the family, such as remaining in school. This means being responsible for school work, attendance, grades, and conduct. Responsibility for household duties, and some acceptable level of graciousness and cooperativeness at home might be important to you, too. Let your child know that these things are expected. It then becomes his or her task to maintain the mental, emotional, and physical capacity to meet your expectations. That task may or may not be compatible with a certain amount of continued drug use. The point is, you can *see* whether or not your expectations are being met. You may not always be able to see whether or not your child is using drugs.

It's generally more pleasant and constructive if you and your children can discuss and develop family rules together. It makes your job as a parent easier if your children appreciate the need for rules and expectations that express your values and preferences. It may help you to feel you've done your job well if they are willing and able to acknowledge the fairness of your setting limits on their behavior or your own. We encourage you to work toward this kind of relationship within your family. We realize that you won't *always* be so fair and patient, nor will your kids always be so understanding.

If your child's behavior does not meet your minimum expectations, you need to be certain what consequences you are willing and able to impose. Again, we urge you to do this in a firm, clear, and impersonal way. "Impersonal," in this context, does not mean uncaring and cold. Rather, it means making a statement that your expectations are not met, and that you must set limits or impose consequences as a result. Don't degrade, judge, or diagnose the child personally. Don't require him or her to *agree* to being bad, crazy, stupid, or guilty. Although for younger teens you may want to use such consequences as grounding, for older adolescents it probably makes more sense to simply set limits on your support for their lifestyle. That might mean personal services such as laundry, use of certain areas of the house, money, transportation, food, or, ultimately, even the privilege of living at home.

You may decide that your child, or the whole family, should see a counselor, or that the child needs to be in a residential treatment program. This is a powerful statement that you see the child's behavior as a serious matter. You can help by not presenting the treatment as a punishment, or a burden that the child has single-handedly inflicted on the family. It is your choice to make use of treatment services. You have the responsibility for that choice.

The parents need to come to a joint decision, one that each can support, regarding the necessity for treatment. You need to decide whether or not you will give your child any choice in the matter, and what consequences will follow if he or she refuses, *before* the matter is discussed with the child. If this decision-making process proves difficult, we'd suggest that you make use of a parent support group or a family counselor to assist you. This doesn't mean that you enter discussion with your teenager with your mind already made up and closed. It means that you and your spouse are clear about what the issues are for you, what your feelings are, and what alternatives you are willing to offer your child.

WHEN YOUR CHILD IS AN ADULT

Often parents continue to feel a great deal of concern and responsibility over the drug-using behavior of a "child" who is no longer a minor and who may or may not be living in their home. They may be concerned about the possible moral and physical harm that drugs can cause. And they see the drug-related problems and inadequacies in their children's lives as convincing proof that they are "victims" who are actually unable to help themselves.

It is hard for parents (and spouses) to give up the fantasy that they can "help" other adults by taking responsibility for them, rescuing them, protecting them, and controlling their (sick, bad, crazy) behavior. This is almost *never* the case. The most helpful attitude seems to be one that says, in a firm and friendly way: "You must live with the consequences of your own choices; I love you, but I will not allow your behavior to control my life. I know that I cannot control you."

Some young adults, however much they appear to resent parental control, will still expect assistance or rescue when they get into difficulty. At least, they won't refuse it if it's offered. They might hear a statement like the one above as a withdrawal of love—and a completely unjustified one at that. They might react with anger, and with stepped-up attempts to get support from the family. Some parents find it very painful to resist giving support. They feel guilty about "abandoning" a child in trouble. They do not want their children to be angry with them. They see the drug abuser as "sick" and therefore incapable of self-help. Their definition of family relationship may include the notion that family members stick by each other no matter what. Parents in such a situation can use practical advice or emotional support. Groups such as *Toughlove* or *Families Anonymous* may be helpful here. *Al-Anon* has a wealth of experience in providing non-coercive, non-judgmental support for families who need to re-think their relationship to substance abusers in the family.

It is seldom true that only one way exists to respond to a troubling family situation. Few family problems are more troubling to parents than the use of drugs by their children. We want you to know that you have choices. You can respond to this problem in a way that best fits your sense of what is right. Some responses will turn out to be more effective than others. Throughout this handbook, we have emphasized a style of parenting that we believe will be effective in helping you prevent substance abuse in your family, *and* in dealing with it if it already exists.

Above all, remember that no family can expect to cope all by itself with a problem which exists nationwide. Don't hesitate to make use of the outside resources in your community. Use the reading materials available from libraries and community agencies. Use the support, counseling, and other treatment available from professional programs and family self-help groups. And make use of other parents in your neighborhood who share your concerns—all of you may benefit, together with your children.

In the final chapter of this handbook, we have provided some basic information on commonly abused drugs. It is as complete and up-to-date as we could make it in a booklet of this size. In case you're interested in obtaining more detailed information about certain drugs, *or* if you're curious about specific parenting techniques we have suggested, we have provided a list of suggested readings in the back of the book so that you can explore these ideas further.

CHAPTER 6

BASIC DRUG INFORMATION

MARIJUANA

Marijuana is a plant product consisting of the leaves and flowering tops of the hemp plant (*Cannabis sativa*), which is widely grown throughout the world. It looks like crumbled, dull green or brownish leaves, and gives off a sweet, pungent smell when burned. It is usually rolled into cigarettes or smoked in water pipes called "bongs," although it can be cooked in foods (such as brownies) and eaten. Marijuana travels under a good number of pseudonyms on the street, including grass, pot, weed, dope, reefer, boo, or any of a dozen other names.

Hashish (hash, hash oil) is made from the resin produced by the flowering tops of the same plant. The major active ingredient in both marijuana and hashish is *tetrahydrocannabinol*, or THC. While THC does not cause true physical dependency, prolonged heavy use may result in mild to strong psychological dependency.

Marijuana produces a sensation of euphoria and mild disorientation, especially in new users. Sensations are experienced more vividly, and a user's sense of time may be distorted. Motor function is also impaired during the period of marijuana intoxication, much as it is with alcohol, so it is not safe to drive a car or operate machinery while "high" on the drug. Marijuana's effects may last from 30 minutes to several hours, depending on how much THC is taken into the body. THC absorption is dependent upon the THC content of the marijuana and quantity consumed. Other short-term effects include impairment of short-term memory (memory of events occuring within the last few minutes) and increased appetite. The user's heart rate tends to increase, the whites of the eyes may become reddened, and the mouth can become dry.

Throughout the years, there has been much controversy over the possible long-term effects of marijuana. Unfortunately, until relatively recently, most of the research done on long-term effects has been poorly designed, and frequently performed by experimenters who were biased—either for or against the use of the

drug. Other researchers, attempting to repeat their experiments, have gotten different or inconclusive results. During the last five years, some reliable and reproducable research has been performed. *It indicates that some level of risk does exist for certain groups of individuals.*

Marijuana does increase heart rate and may induce tachycardia in some users. Because of this, marijuana may be harmful for people with cardiac problems. It does not appear to increase heart rate to dangerous levels in users with healthy hearts.

Marijuana smoke has been shown to contain many of the same cancer-causing chemicals as tobacco, and can be irritating to the throat and lungs. People with respiratory problems, such as bronchitis, asthma, or emphysema, are at risk. As with long-term heavy smoking of regular cigarettes, there may be an increased risk of lung cancer. It is interesting that THC has been tested as a *treatment* for asthma, because it does dilate the bronchial tubes. However, because the smoke is so irritating, it could only be used for this purpose if taken into the body some other way.

Marijuana use does not appear to cause any increase in birth defects, but heavy, long-term use does increase the probability of stillbirths and death of newborn infants. Pregnant women, or those expecting to become pregnant in the near future are at risk. These effects appear to be reversible—that is, when the use of the drug is discontinued for six months or more, normal pregnancies can be expected at the same rate as for the general population.

Heavy, long-term use also appears to cause a reduction in fertility for both males and females. This effect disappears when use is discontinued.

Because of the effects of marijuana on short-term memory, learning that takes place while intoxicated is not well retained. This should make obvious the disadvantages of pursuing an education while stoned. Young people in junior high school, trade school, or college who smoke before class or while attempting to study are wasting their time.

Adolescent users may be at risk in another sense as well. The teenage years are the time in which valuable learning about oneself and the world generally takes place. Meeting challenges, overcoming frustration, and tolerating anxiety play an important role in this learning process. Users and their parents both should be concerned about the potential dangers of inhibiting or blocking out this important element of growing up. Marijuana has been said to cause an "amotivational syndrome," a state of apathy and inactivity sometimes observed in adolescent users. Frankly, it does not seem possible to say with certainty which is the chicken and which the egg. Does marijuana cause apathy, or do depressed, anxious,

apathetic people become heavy users in an attempt to deal with their distress? In either case, it's important to deal with the apathy. If marijuana does not cause it, then something else does. Treatment is made more difficult by masking the underlying problem with a drug. Teenagers who exhibit these symptoms do need help—and their drug use may not be the only thing they need help with.

ALCOHOL AND OTHER DEPRESSANTS

One large group of drugs can be considered together in that they are all central nervous system (CNS) depressants. This group includes *alcohol*, the *barbiturates*, and *non-barbiturate sedative-hypnotics*. Commonly used barbiturates are secobarbital (Seconal, "reds"), pentobarbital (Nembutal, "yellow-jackets"), amobarbital (Amytal, "blues"), Tuinal, and phenobarbital. Non-barbiturate sedatives may include Quaalude or Mequin ("ludes"), Dalmane, Doriden, Placidyl, etc. These drugs produce initial relaxation and euphoria, followed by motor impairment, confusion, and slurred speech. Increasing dosages beyond the normal therapeutic dose decrease reflexes, pulse rate, blood pressure, and respiration. Overdose can lead to coma, to brain and nervous system damage, and to death through respiratory failure. The effects of any CNS depressant will act additively with the effects of any other, thus increasing the danger of unintentional overdose. Alcohol and sedatives should NEVER be combined.

All depressant drugs are capable of producing some degree of physical dependence if sufficient quantities are taken over a long enough period of time. They also produce tolerance, to themselves and to each other. It is important to determine the level of physical dependence before attempting withdrawal from any of these drugs. Heavily dependent individuals should be withdrawn in a hospital setting, since convulsions are possible during withdrawal.

Continuous usage of depressants over time, even at therapeutic doses, may lead to less restful sleep and result in increased tension and irritability. At heavier dosages, users may experience blackouts (temporary loss of memory), and reduced ability to think clearly and perform ordinary tasks. Changes in personality, such as increased hostility and irritability, may be noticed as a result of prolonged use.

Excessive alcohol use is becoming more common among young people as the popularity of other drugs decreases. This drinking pattern is frequently maintained into adulthood. Alcohol is a legal drug for adults, and is not difficult for teenagers (or even younger kids) to obtain. While officially disapproving of drunkenness, in practice we may wink or laugh at the bizarre behavior of someone 'under the influence"—particularly if he or she doesn't live at *our* house. In many social circles, excessive drinking, especially by young males, is tolerated as a sign of manhood. To a limited extent,

the irresponsible behavior of drunks is excused, simply because they're drunk, or "having fun."

For those who have to live and work with the heavy drinker, such antics are not really any fun at all. We do our kids no kindness when we treat excessive drinking lightly *or* when we model it for them. In addition to its high social cost, alcohol in heavy doses does gradually damage the liver, pancreas, and nervous system. It is potentially one of the most dangerous drugs available in our world. If you drink, and if your kids are going to drink, it is very important that you teach them, by statement and by example, to drink with a sense of responsibility for themselves and those around them.

The most immediate danger, of course, comes from driving a car after drinking or taking any other sedative drug. Many young people and adults are killed in this way every year. Be sure to impress on your kids that they should not drive while intoxicated, or ride with a driver who is. Whatever your views on drinking, make sure that your kids have alternatives to these dangers. They can call you for a ride, or to let you know they'll be at a friend's house for the night. The inconvenience is better than death or permanent injury. You can always discuss rules and behavior when they are home safe again.

HEROIN AND OTHER NARCOTICS

Another large group of closely related drugs are the opiates. Four of these—opium, morphine, codeine, and heroin—are derived directly from the juice of the opium poppy. Other drugs, such as methadone, Demerol, Dilaudid, and Percodan, produced synthetically, are close chemical relatives, and produce similar effects. All opiates produce physical dependency to some degree, although the amount of the drug required may vary. They all produce tolerance and cross-tolerance. They tend to produce a marked degree of psychological dependence in long-term users. Heroin and morphine are usually injected, although heroin can be sniffed ("snorted") or smoked. The other opiates are more frequently used in pill form—but can be dissolved and injected ("shot" or "fixed") as well.

These drugs cause initial euphoria and insensitivity to pain and anxiety. Other effects are drowsiness, constricted pupils, constipation, and lowered respiration and blood pressure. Unlike the barbiturates and alcohol, opiates do not cause aggressive behavior while the user is intoxicated. However, the unpleasant symptoms that occur when the physically dependent user is deprived of the drug may lead to agitated and highly irritable behavior. Users refer to these symptoms as being "sick," and they do resemble a bad case of the flu—chills, muscle cramps, runny nose and eyes, diarrhea, vomiting, and anxiety. Nonetheless, opiate withdrawal rarely involves any serious medical complications.

Other potentially serious effects of long-term use of narcotics may include malnutrition, infections from dirty needles, or reactions to various substances used to "cut" the drugs. Other problems may result from any number of physical ailments which go unrecognized or untreated due to the user's indifference and insensitivity to pain. Surprisingly, the drugs *themselves* are far less likely than alcohol, barbiturates, or stimulants to cause damage to the nervous system or internal organs. Aside from the danger of overdose, which can be life threatening, damage most often results from the indirect causes mentioned above, as well as from legal and social problems arising from a lifestyle centering around procuring and using illegal drugs.

AMPHETAMINES AND OTHER STIMULANTS

Included in this category are the amphetamines such as Dexedrine, Benzedrine, and methamphetamine; other medications sometimes prescribed for appetite control such as Preludin and Tenuate; Ritalin, caffeine, and nicotine. These drugs, sometimes called "uppers" or "speed," stimulate the central nervous system, producing feelings of energy, well-being, and confidence. They serve, at least initially, to decrease appetite and relieve fatigue and boredom. Because users rapidly develop tolerance, these effects disappear after several weeks of use, unless the dosage is dramatically increased.

Although nicotine is the only substance mentioned which is known to produce physical dependence, withdrawal from extensive use of stimulants presents certain problems. The person using large doses of stimulants has been running his or her body at "high speed." Energy and alertness have been artificially produced, cancelling the brain's normal messages about needing rest and sleep. When use is discontinued, the body and brain suddenly feel the effects of these unmet needs. Fatigue and depression set in ("crashing"), sometimes with alarming intensity. Long-term users who may have liked the stimulant effects because they were depressed to start with may become suicidally depressed during drug withdrawal. Other than guarding against this possibility, little in the way of medical treatment is required.

Long-term, heavy use of amphetamines may result in the appearance of a "toxic psychosis," characterized by hallucinations, extreme irritability, paranoia, "crawling" skin, and behavior resembling a schizophrenic episode.

Cocaine is also a stimulant. It is usually seen as a white powder extracted from the leaves of the coca plant, which grows in the high mountain regions of South America. In recent years, it has developed a reputation as a "glamour" drug, largely due to its expense (high-quality cocaine can cost up to $3000 an ounce), its

pleasurable effects, and its presumed harmlessness. Cocaine is similar in its effects to other stimulants. It does not produce physical dependence, but tolerance to its effects does develop. Both formal research and observation have shown cocaine to be a highly seductive drug—psychological craving develops easily in some individuals, and usage seems to be limited mainly by availability and price. Cocaine is usually "snorted," but when chemically treated, it can be smoked ("free-basing"), and some users shoot it to get a more intense, faster-acting effect. Heavy, long-term use may produce tissue damage to nasal membranes or injection sites.

LOOKALIKES—Another category of stimulants readily available to kids today are known as "lookalikes." Although there are lookalike copies of a number of drugs on the street today, most often lookalikes are made to look like standard amphetamines. They usually contain caffeine, in combination with various over-the-counter medications, such as phenylpropanolamine and ephedrine. They are quite legal, in most states, and are openly sold at concerts and in "head shops" and by mail order. But even though the ingredients in lookalikes are legal, that doesn't mean the drugs are entirely harmless. Taken in sufficient quantity, these drugs can produce restlessness, insomnia, hypertension, agitation, and hallucinations. Several cases of lookalike-related deaths have been reported, probably due to extreme hypersensitivity to one or more of the ingredients of the drugs. People with heart disease, hypertension, diabetes, or thyroid problems should avoid these substances.

Another danger of lookalikes involves the risk that users run when they become accustomed to using the drugs in large quantity. If they somehow unknowingly obtain the genuine amphetamines that lookalikes are modeled after, serious overdose could easily result through the user taking a standard dose of the same apparent drug.

PHENCYCLIDINE (PCP)

This drug, classified as a hallucinogenic, or dissociative anesthetic, is still widely used by many young people, partly because it is relatively cheap and easy to manufacture and purchase, and partly because of its potent and unpredictable effects. The most common street name for PCP is "angel dust," but it is widely known by a number of other names, masquerading as a variety of different drugs. It can be sold as powder, tablet, or liquid, and is sometimes mixed with vegetable matter and smoked, or dropped onto pre-rolled cigarettes ("Shermans"). PCP is also sold on the street as THC, the active ingredient in marijuana, due to the similarity of their effects at low dosages.

The similarity of the PCP "high"(at low dosage levels) to that of marijuana represents one of the most serious dangers of the drug. Users are often introduced to PCP through "dusted," or PCP-contaminated joints or cigarettes, and the effects of a single joint are often similar to mild marijuana intoxication. However, as dosage is increased (often through smoking a second or third dusted joint), a wide variety of effects can be produced. Due to PCP's complexity as a chemical, the drug produces a wide range of subjective effects, including feelings of well-being and detachment, along with a range of thought and perceptual distortions. As the dosage increases, the user becomes intoxicated, may appear to be drunk, or might exhibit any of a variety of symptoms: inability to talk, severe agitation and paranoia, fixed staring or rapid, jerky eye movements, and muscle rigidity. At still higher doses, coma, respiratory depression, seizures, and death may result.

Because the effects of the drug, both during and after use, vary from one user and from one episode to another, it is not possible to describe effects which will always occur, or happen in the same way. We should note, however, that PCP is one of the few drugs which appear to produce recurring effects some time after the last use. Some users experience hallucinations, feelings of being "crazy" and difficulties with speech and memory as long as six months to a year after last use. These effects are more common with chronic users, but have been reported by occasional users as well. Eventually they disappear, but in the meantime, the individual may develop psychological problems and a role in his family as a "crazy" person. Supportive counseling may be helpful.

LSD AND OTHER HALLUCINOGENS

This category includes a wide variety of drugs which produce sensory distortions and hallucinations. They come from a number of sources—LSD, for instance, is produced synthetically in a laboratory, while mescaline and psilocybin are plant derivatives. A host of chemicals related to amphetamines also are used for similar effects.

The short-term effects of hallucinogenic drugs can vary enormously. The user's experience while on the drug is highly subject to his mood and surroundings—and can range from ecstatic pleasure to extremely fearful panic reactions. Medical assistance is rarely needed during "bad trips," but the user who is having a bad experience needs to be kept calm, while being reassured that the effects he is experiencing are the result of the drug, and that it will wear off in a few hours.

Occasional horror stories to the contrary, it is unlikely that LSD or other similar drugs will cause a psychologically healthy user to jump out of a window or become permanently psychotic. Neither do they appear to cause physical dependence or overdose. However,

these drugs should definitely be avoided by individuals who have a diagnosed emotional disturbance, or are severely depressed or anxious. The drug-induced experiences only make it harder for such people to evaluate what is reality and what is not, and to continue to think rationally. They are far more likely than the ordinary user to interpret their "unusual" experiences, *however* induced, as meaning that they are crazy and out of control.

There is still much controversy over the widely publicized "flashback"—a recurrence of panic, sensory distortions, or hallucinations some time after the drug effects have worn off. These effects do not appear to be due to physical residues of the drug in the body. It's more likely they are caused by memory cues and associations established during the drug experience and triggered by similar experiences later, much like the "dèja vú"experience that occurs in all people from time to time. While the flashback experience may be alarming, it is usually not dangerous, and rarely long lasting. Understanding what it is, and is not, usually helps the person to avoid escalating the occurence into a crisis and dwelling on it, which only intensifies and prolongs the problem. If the flashbacks persist, counseling may be helpful.

INHALANTS: SOLVENTS, AEROSOLS AND NITRITES

Breathing fumes from these substances is an easy way to produce feelings of relaxation, giddiness, and euphoria. A wide variety of chemicals will produce these effects, and they are inexpensive and readily available. Due to their low cost and easy availability, inhalants are widely used by a good many young people, particularly by those less able to afford other chemical routes to getting high. And unfortunately, inhalants are among the most dangerous substances that kids are likely to get into.

VOLATILE SOLVENTS: GLUE, PAINT AND GASOLINE—Volatile solvents produce effects similar to alcohol. The user acts drunk, slurs his speech and staggers. The effects usually last less than an hour. Very frequent or intensive use can cause hallucinations and deadening of the senses. Tolerance develops with prolonged use, which increases the risk of overdose. Poor coordination and difficulty in thinking clearly and concentrating can also occur. Chronic, high-dosage use that persists for several months or longer can result in permanent damage to the nervous system, bone marrow, liver, and kidneys.

Because inhaling these chemicals permits almost immediate absorption in the brain, overdose may occur rapidly, without any warning. Loss of consciousness, even death, can occur almost instantly. Sudden shock or strenuous activity while heavily intoxicated can also result in immediate heart failure.

AEROSOL SPRAYS—Aerosol sprays pose a somewhat different danger. The intoxicant here is usually Freon®, or another propellent used to make hairspray or cooking oil or deodorant spray come out of the container. Aerosol propellents produce a very brief high. However, in the process of inhaling the propellents, users also inhale greater or lesser amounts of the substance being sprayed—whether hairspray or deodorant or cooking oil. As a result, the lungs become coated and suffocation can result.

NITRITES—Nitrites include chemicals like amyl and butyl nitrite and nitrous oxide. Amyl and butyl nitrite produce a short, very intense high. They are sold as "liquid incense" or room deodorizers. Nitrous oxide, sometimes called "laughing gas," produces spasms of helpless laughter in users. It is sometimes used by dentists as an anesthetic. Compared to the volatile solvents and aerosols, the nitrites are relatively harmless. It should be emphasized, however, that *any chemical, even if it is harmless in itself, can cause suffocation if a large quantity is suddenly inhaled.* There simply isn't room in the lungs for sufficient oxygen to keep the user conscious.

CHAPTER 7

SOME FINAL COMMENTS

The area of drug use and abuse is a very broad one. It involves a host of medical, psychological, legal, social, and value-oriented questions, as well as a wealth of detailed information about specific drugs and drug categories. We can only begin to address such complex issues in a handbook such as this one.

We have tried to give you a social and family context in which to examine the issues raised by the use of drugs by children and adolescents. We've suggested some ways in which the family can use its own resources, and other resources in the community, to help prevent or minimize substance abuse by young people. We've talked a very little bit about treatment services, which vary widely from one community to another. And we've presented some basic information about the effects and dangers of common drugs.

We haven't attempted to answer all the questions about drug abuse and the family in this handbook. That is a study that would take a lifetime and one that would fill a library. What we *have* attempted to do is provide you with a starting point, a point of departure, from which you can begin to make your life, and the lives of your family, work a little better. And if we've learned nothing else along the way, we've learned that making our lives work, and the lives of the people we care about, requires the full commitment of everyone involved.

You've taken on a big job as a parent, the biggest job there is, in fact: helping to shape the values and feelings and ideas and dreams of your children into those of the men and women they will become. It's a big job, but one that's worth doing. And if we learn to accept and love ourselves and teach our children to accept and love themselves and each other, it's a job that will always be complete and one that will never end.

SELECTED READINGS
RESOURCES FOR FURTHER INFORMATION

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BIOGRAPHICAL NOTE

The author of this handbook, Erica Wittenberg, M.C., worked for seven years on the staff of Terros, Inc., a Phoenix-based agency which provides crisis intervention and long-term therapy to drug abusers. During her last two years at Terros, she served as the Director of Counseling Services. Currently Ms. Wittenberg is in private practice as a psychotherapist, and teaches in a community college program that trains substance abuse counselors. She has three grown children.